

ENTERAL PRESCRIBER ORDER FORM

Patient Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Phone: _____

Height: _____

inches cm

Weight: _____

lbs kg

Clinical Information

Primary Diagnosis Description: _____

ICD-10 Code: _____

Allergies: _____

Enteral Tube Placement Status

Tube placed – Date: _____

Tube placement pending – Anticipated date: _____

Type of feeding tube placed or anticipated type to be placed:

NG (nasogastric) tube

G-tube (gastrostomy or PEG)

G/J-tube

NJ (nasojunal) tube

J-tube (jejunostomy or PEJ)

Other: _____

Type of connection: ENFit Legacy

Prescription (Select One of the Following Options)

Option Care Health dietitian to assess patient's needs and recommend initial feeding plan, additional free water flushes, and advancement to goal.

Enteral nutrition as follows:

Feeding Method:

Syringe (bolus) Gravity Pump

Formula Name: _____

Equivalent formulations may be substituted where clinically appropriate.

Check here if formulation substitution is **not** permitted – .

Feeding Plan:

Please indicate amount and frequency.

Additional Free Water Flushes:

Please indicate amount and frequency for tube patency and patient hydration.

Anticipated duration of therapy: _____ year(s) months weeks

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name: _____

Phone: _____

Fax: _____

Address: _____

NPI: _____

City, State: _____

Zip: _____

Office Contact: _____

Fax completed form, insurance information, and clinical documentation to:

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

Not valid for use for patients residing in Arizona, New York, and Wisconsin